

Nursing Home Incentive Program  
Stakeholder Advisory Group  
Friday September 18, 2015  
1:30pm – West Wing Conference Room

Deidre Gifford, Matt Trimble, Jim Nyberg, Deb Correia Morales, Rosa Baier, Jay Bruchner, Michael McMahon, Akshay Talwar, Jennifer Fairbank, Hugh Hall, Beth Marootian, Virginia Burke, Sophie O'Connell

- I. **Welcome** – Deidre Gifford welcomed members to this open public meeting, and thanked everyone for their time. Introductions were made around the table (see attendees).

A draft of recommended metrics was shared with attendees. (Email [lauren.lapolla@ohhs.ri.gov](mailto:lauren.lapolla@ohhs.ri.gov) for a copy.) Deidre Gifford noted that we received several specific measure suggestions that were incorporated into the draft. If others arise during the meeting, they could be added.

II. **Update on DSRIP Status with CMS**

An overview document outlining the goals and components of the RI DSRIP program was provided to attendees. (Email [lauren.lapolla@ohhs.ri.gov](mailto:lauren.lapolla@ohhs.ri.gov) for a copy.) Deidre reviewed the timeline (are in conversation with CMS now, with formal submission slated for October/November. RI is looking for approval by the end of the State Fiscal Year, to implement the incentive program in the next Fiscal Year. (This is contingent on agreement with partners in the General Assembly.)

Deidre addressed questions from the last meeting, including a question about how the one-year incentive program fits into the larger DSRIP concept for RI. The draft document articulates this and how preliminary funds could be broken down into three components:

1. “Institutional transition program” -- where incentives for qualified hospitals and nursing facilities would be implemented. Deidre noted that this is where the process the group is engaged in now is focusing. As proposed, a small percentage of total 5 year DSRIP would apply to this component.
2. “Transition to accountable entities” -- to transition the delivery system from a volume-based, fee for service system to one that is value- and quality-based.
3. “MCO Transformation Incentive” – focuses on incentives to assist managed care organizations in making the transition from volume

to value based purchasing. Deidre notes that the state and MCOs need to evolve alongside providers, to ensure we have capacities and infrastructure we need to support value-based entities.

Question: We talked about budget neutrality in last meeting. In DSRIP, do they worry about outcomes you've proposed and budget neutral

Deidre Gifford: Yes, it is an 1115 waiver, and our proposal would be a modification to that, so we have to demonstrate budget neutrality.

### **Questions, comments, and discussion**

An attendee mentioned the CNOMs allowed by CMS under the 1115 waiver a few years ago, and whether this represents a delivery system CNOM. Another attendee asks whether percentages will be combined into a single tool, or constitute separate pots of money.

Deidre Gifford: The idea, as we are proposing it, would be to move the incentives from being focused on a single industry or provider type to being focused on providers who are working together across the delivery system as accountable entities. In NY, they call them "Performing provider entities" and they don't have to be formal ACOs or AEs with a unified ownership or contracting structure, but they do need formalized agreements in order to qualify for DSRIP funds. (With the exception of the first year of DSRIP in NY, which was focused on institutional providers as a transition year to help them make the transition to accountable care.) We haven't really addressed where the state share of the funds for DSRIP would come from. Are you asking whether the Nursing Home would be asked to contribute dollars to this state share that would then be shared across the entire provider community?

Jim Nyberg: That's part of this, and also that the money was initially coming from rate cuts for hospitals and nursing homes. Is there a different perspective now?

Deidre Gifford: No, that money came out of the budget in this Fiscal Year. The proposal is to offset with some of these incentive measures the underlying expenditures in the industry such that we could re-appropriate in some fashion the state share of that money. That's a separate process from reductions that happen in the current FY.

Hugh Hall: If you're reducing nursing homes by 2% do you have to give matching piece to the feds?

Deidre Gifford: Every dollar not spent by the state is essentially \$2 not spent in the general healthcare delivery system.

Beth Marootian: Are you seeking DSRIP authority before you'll put the nursing home incentive program in place?

Deidre Gifford: We will need that authority to draw down the federal match potentially. For the next year, the Institutional Transition Program would not necessarily flow through managed care.

The group reviewed the next page of the document, which provides more detail about the ITP component. (Email [lauren.lapolla@ohhs.ri.gov](mailto:lauren.lapolla@ohhs.ri.gov) for copy of this document.)

Deidre notes that hospitals feel the measures for this part of the program should focus on utilization and demonstrating cost effectiveness, to show that DSRIP will be a successful way to invest state funds. (The state initially thought people would be more focused on structural milestones, and there was some interest in that, but a greater focus was on six or seven core clinical measures on which consensus was reached (e.g. ER use, readmissions, hospital acquired infections, follow up after behavioral health admission, etc. – measures that drive cost in hospitals). The next step is for the hospital stakeholder advisory group to meet with the nursing home stakeholder advisory group jointly to see where we can come up with cross cutting measures, and focus on structural measures.

An attendee asked whether the workforce development focus may change, based on nursing home requirements.

Deidre Gifford: If the group feels that would advance the cause of the program, I don't see why we wouldn't entertain it.

Hugh Hall: One stumbling block may be attending physicians and their willingness to subsidize the cost of that individual or share the bill of visits with the individual. This may vary based on scope of practice – larger group practices may be more willing.

Beth Marootian: When I look at the Workforce Development example, it seems more like a program initiative. There may be other things to incorporate, such as the pipeline of Nurse Practitioners in RI.

An attendee suggested the question to ask is how to attract nurse practitioners to the long term care field.

Hugh Hall: Noted the existence of many stumbling blocks – doctors working for different systems, etc.

Deidre Gifford reminds the group that the plan would be for us to be in measurement year one right now, for incentives to be distributed in the next fiscal year (with General Assembly and CMS engagement and

approval). These need to be things we can act on in the next 7-9 months, to make a distribution in first quarter of next fiscal year. Suggests that the idea posed by the attendee may be more applicable to the broader Accountable Entity component.

Beth Marootian: It does raise a point about the regulatory barriers that may be in place and need to be addressed to allow integration and community based supports, particularly in health in the nursing home and assisted living world and where changes need to happen.

Akshay Talwar: ACOs as they seem to be forming are limiting membership in ACOs in other states. Consultants have said they're starting with large numbers of participants, then excluding certain groups to narrow down the numbers. If we are only going to focus on ACOs, by definition we might exclude half the population from participation. This may hasten the decline of excluded entities. This may not even be a quality measure – ACOs are willing to accept three-star members if the price is right.

Deidre Gifford: This is a critical point about accountable entity formation. One of the reasons we're trying so hard to get these guidelines right is exactly this reason – states and payers must thread the needle between driving appropriate industry consolidation for value & making sure providers are affiliating to the extent they have the capital and resources, and the need to not have critical providers left out of the system. In fact, that's what the first year of this program could be designed to do, and it is how we've written it for CMS. Need to think about appropriate awards and incentives here. Providers will need to affiliate in some way in most instances, and we recognize that's a big change, but it appears to be happening all over the industry and country.

Akshay Talwar: The power structure is other people at the apex, like hospitals, insurer and provider groups (doctors). Nursing homes are never invited to the table. This may lead to unfavorable results where people will be driven out when you most need them. This is not a time to drive low-cost providers out of business.

Deidre Gifford: We agree, and we hear the same thing from primary care providers about hospitals driving the AE formation. There are two levers we propose to get at this problem in AE guidelines. 1. Governance standards. We need your assistance in giving us ideas on how this might affect your industry. 2. Metrics – e.g., AEs may need to demonstrate that certain star-level nursing homes are included in their organization. If we get it right, we won't disadvantage low-cost, high-quality homes.

Akshay Talwar: Sometimes, national chains and players have an advantage. Some arrangements being created are so complex that the local provider can't expect to understand what's going on without the participation of someone like Remedy Partners. It becomes very unfair.

Deidre suggests keeping these concerns in mind as the group walks through the proposed measures.

### III. **Review Proposed Clinical Measures**

Proposed measures were presented. (Email [lauren.lapolla@ohhs.ri.gov](mailto:lauren.lapolla@ohhs.ri.gov) for a copy.)

#### **Discussion, comments, questions:**

##### *Governance and new contractual arrangements domain*

Beth Marootian: We provided comments to the RFI and think an incremental approach can be considered when you integrate services, particularly those that haven't been part of managed care.

Hugh Hall: As you're exploring this, what kind of ACO oversight are you envisioning?

Deidre Gifford: It would not be the state. Clarifies that what was proposed for public comment is that the state's role is to set up general guidance for how to structure an Accountable Entity, and have a certification process. Walks through an example.

Beth Marootian: The RFI for this Fiscal Year references a "pilot."

Deidre Gifford: There will be learnings from pilot, certification process, RFI, applications, etc.

Hugh Hall: Have you begun to build the criteria for that application?

Deidre Gifford: Yes. Last week was the deadline for RFI responses, and we have really good information.

Akshay Talwer: I don't see how the nursing home industry has much influence over this process. What is our level of input into this part of the process?

Jim Nyberg: Governance is key, and long term care needs to be involved in that. Technically speaking, these measures wouldn't relate to nursing homes in terms of pay for performance, but they make sense in terms of the bigger picture.

Jennifer Fairbank: They make sense to me more as structures than as measures.

Akshay Talwer: Provides example from New York Medicaid program – ensured that nursing home providers were included in process.

Deidre Gifford: We're looking very closely at what NY is doing, as CMS has directed us there. Qualitatively, we agree with what NY has said. Operationally, need to look at governance and metrics, so we know what fair treatment is, and what is not. We welcome other ideas about how to ensure fairness. (Can't include just any willing provider, as we need to focus on value based purchasing.)

An attendee asks which measures to focus on. Deidre suggests focusing first on identifying half a dozen clinical measures on which the group can reach consensus.

#### *Utilization domain*

Deidre Gifford suggests removing the measure related to number of beds, as it is not a short-term measure.

The group agrees that the measure about the percentage of long-stay nursing facility residents is a great measure.

Jennifer Fairbank: Suggests delineation between patient admitted as a long-term care patient, and the transition of a patient.

Akshay Talwer: Suggests that the measure be acuity adjusted, as populations may vary by facility.

Deidre Gifford: This will be a larger topic we should look at with the hospitals. For this year, we may need to focus on existing measures that are readily available and able to be calculated.

Beth Marootian: This will be part of the DSRIP work.

The group reviews the measure on residents hospitalized within 30 days of admission.

Hugh Hall: It seems unfair to hold the nursing home as solely responsible for this.

The group suggests that the hospital should be held accountable for part of this time period.

Deidre Gifford suggests putting the same measure on both lists. The group agrees this seems fair.

Beth Marootian raises a question about methodology for one of the measures, and whether the measure should remain true to technical specifications.

Deidre Gifford: Once we agree in general on the measure, we can refine the language.

Jennifer Fairbank recommends tweaking the measure on readmissions and notes that surgery readmissions / elective readmissions are different than all-cause readmissions.

Jim Nyberg: Regarding the 30-day readmission -- Keep in mind that the CMS measure will be mandated for all nursing homes. Different from NCQA measure.

Deidre Gifford: Is this a short-stay or long-stay measure? We want to measure the things that predict someone who was short stay turning into long stay, and make sure we're measuring successful transitions.

Matt Trimble: Notes that some nursing homes in RI don't take short stay residents, and may not have the volume required for this measure.

Deidre Gifford: Once we decide what our measures and specifications are, we will need to look at how incentives are tied to achievement of measures. You may not need to improve on all measures – e.g., if you're not eligible for certain measures.

The group reaches consensus on measures related to long-stay residents, residents re-hospitalized within 30 days of discharge, and admissions discharged and remaining in community for 30 days.

Beth Marootian: Notes that it is important to incentivize in areas that need work, not where the industry is doing a great job. This will only come when you're able to establish a baseline.

### *Health Outcomes/Clinical Quality domain*

Beth Marootian: Recommends getting core measures down, then looking at other ways to splice the measures (e.g. by race/ethnicity)

Jennifer Fairbank: Raises concerns about measure on percentage of nursing home residents with low care needs. Certain residents may not

look on paper like they need a lot of care, but they actually do (e.g. patients with dementia who can't live independently at home).

Deidre Gifford: Believes this has been subsequently addressed in methodology. RI has been criticized in the past for percentage of nursing home residents with low care needs. May want to put this measure in, as it's something nursing homes are working on. If we're successful in decreasing utilization of nursing homes, we don't want to lose critical homes. May be able to reward nursing homes that have lost patients.

Beth Marootian: Or to reward the accountable entity.

Deidre Gifford: It sounds like we don't have unanimous agreement on this measure.

Deb Correia Morales: Notes that the next few measures are standard CMS measures.

Jennifer Fairbank: Important to differentiate patients receiving anti psychotics without a diagnosis.

Deidre Gifford: We do well on this measure as a state. May not be one to include.

Certain members note that there is variation by nursing homes. Group suggests the measure should be tweaked.

Deidre Gifford: We shouldn't tweak measures that are standard measures (e.g. 5-star measures, CMS measures, SIM LTC/LTSS measure). We want to be consistent.

Group agrees that it would be best to use the 5-star measures and to use the measures related to falls, pressure ulcers, UTIs, and antipsychotic medications.

Group discusses sharing the measures that come out of this group with the SIM group.

The group also notes, regarding the advanced directive measure, that the percentage is close to 95% or 100% already. May not be a valuable measure. Jennifer Fairbank notes there is a difference between executing an advanced directive and advanced care planning. Should think about a more meaningful measure to use for this topic. This also seems like a measure that overlaps with the hospitals – could be a cross-cutting measure.

### *Care Coordination / Care Transitions domain*

It is suggested that the issue with both measures is likely not the long-term care community, but the hospital community. (It's also noted that the hospital community says the reverse.) The group agrees that this should be a cross-cutting measure.

Deidre Gifford proposes discussing CurrentCare enrollment and getting ADT feeds through CurrentCare as a potential structural measure (electronic transmission of information), and mentions a new grant recently awarded in this arena.

Matt Trimble: Discusses current process at Saint Elizabeth Community.

Hugh Hall: Asks about the intent behind CurrentCare.

Deidre Gifford: Ideally, would receive an electronic notification of transfer (including family members), and an accompanying clinical summary.

Jennifer Fairbank: Describes challenges with CurrentCare that could become barriers, such as not being able to view behavioral health information, and not having an accurate medications list. Without mandating that everyone use CurrentCare, those gaps will still exist.

Deidre Gifford notes that the grant recipient will be asked to come to this group for a future meeting.

### *Patient Engagement & Satisfaction domain*

Jay Bruchner: Nursing home residents don't participate in health claim CAHPS, but it looks like there is a nursing home specific measure. (Unclear if this is being utilized in RI.)

Group agrees that if there is already a resident satisfaction survey that is what should be use.

#### **IV. Joint Meeting with Hospitals:**

Proposed for the morning of October 8 but an email will be sent out to confirm. Group notes that this may conflict with an American Healthcare Association event in San Antonio. Later morning would be preferred. Joint measures will be discussed at that meeting, and potentially the issue of risk adjustment for acuity and patient characteristics. Staffing-related issues and structural measures can be discussed at subsequent meetings.

Beth Marootian: Requested that the short list of hospital measures and nursing home measures be shared prior to that meeting.

Jay Bruchner: Notes that NHPRI reports two measures on pain management to the state, and also suggests medication reconciliation as a measure. (Medical recommendation at the time of transition would be ideal)

Michael McMahon: Notes that NY uses immunization, but group notes that RI's rates are pretty good.

V. **Public Comment**

No additional public comments were raised.

VI. **Adjourn**